Meaningful Use Workgroup
Draft Transcript
January 8, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you. Good morning, everybody, and welcome to the Meaningful Use Workgroup, part of the HIT Policy Committee. Just a reminder, this meeting will be, is being conducted in public, which means there will be a transcript posted on the ONC Web site within the week, and the public will be invited to make comments at the close of the meeting. Just a reminder for everybody to mute your line when not in use, and please identify yourself for proper attribution. Let's do a roll call now. David Bates? Christine Bechtel?

Christine Bechtel - National Partnership for Women & Families – VP
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman? Paul Tang?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw?
Deven McGraw - Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Linda Fischetti? Tony Trenkle?

Tony Trenkle – CMS – Director of OESS
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Farzad Mostashari? Charlene Underwood? George Hripcsak?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave any workgroup members off that roll call? Okay. Let me just turn the line over to Chris Weaver for a moment to talk about the Web cast. Chris?

Chris Weaver – Altarum
Thanks, Judy. We just know there could have been a little confusion on the HHS Web site, so if anybody is trying to log in via the link that's on the HIT Policy page, that link ends in hitpolicy. The link for this workgroup is actually different. If you want to log in via the Web, the link is http://altarum.acrobat.com/mu for meaningful use. Thanks, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, and I'll turn it over now to Dr. Tang.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you, Judy. And thank you, everyone, for participating in this call. I want to start out by congratulating both CMS and ONC for a tremendous effort throughout the past several months and culminating into the almost published, but released NPRM over the holidays. It certainly kept the offices busy, and I think a lot of us have trickle down effects, which kept us busy as well, but thanks, and congratulations to the team.

The other thing I want to do is update the schedule. I talked with Tony prior to this call, and in the e-mail, I talked about some of our deliverables, as we knew them before, but Tony had reviewed them with the other CMS leaders, HHS office, and came up with sort of a schedule for us. In the end, they would like to have any feedback, formal feedback from our workgroup through the committee by March 1st in order to keep up with their timetable. Working backwards from that, that would mean that by the February meeting of the full committee, we would want to have presented our draft recommendations for their review, comments, and finalization so that we can turn it around and produce a letter that we can deliver up to CMS. Working back from that, that means that at this meeting next week of the full committee—

Tony Trenkle – CMS – Director of OESS
Paul, excuse me. This is Tony. The letter would go to ONC, not CMS. The committee is responsible for writing recommendations to the Office of the National Coordinator.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks for correcting that.

Tony Trenkle – CMS – Director of OESS
Sure. No problem.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So that means next week what we'd like to do is try to give the full committee a heads up in some of the areas that we think we'd like to deliberate more fully and get their initial comments as well. So the goal for today would be come up with essentially an annotated list, a list of topics that we'd like to summarize and put forward to the main committee. Our focus will be on, let me call it, the philosophical comments. Let's put sort of three buckets of commentary, as one might be the sort of philosophical comments.

What's an example in the quality measures? We had taken an approach. We had recommended an approach of, we called it, exemplar measures. And by that we meant if you were able to report on and to improve your performance on a given measure, on a given exemplar measure, that means you probably

purchased a comprehensive EHR system that had the capabilities that affect your practice, that you probably built it and configured it so that it would be fully effective, and that you trained and implemented the system. You implement the system and train the users to make full use of that system, and then provided feedback so that the system could be your group of, whether it's a hospital or physicians or other providers, could continuously improve their performance. That was sort of the rationale behind the exemplar approach.

The other side of the spectrum, we sort of informally labeled it the 500 measures approach is to have a large set of measures from which individual providers could pick and choose. On the spectrum of things, the NPRM looked more like the 500 measure approach than the exemplar, so that's an example of a philosophical difference where we could talk about it, discuss more, and look at the rationale for picking that approach and see what comments we might have.

Another bucket of comments might be simply answered, even in this call or with follow-up, and those might be clarification questions, so the statement … a statement was made in the NPRM. It leaves opens some questions. What's the answer to those questions? And that kind of thing can help ONC and CMS fine-tune the language so that it's clearer.

And a third might be getting down into the granular items … and here's another alternative, and this is the rationale for considering this other alternative. I think we all think there's going to be a lot of public comment coming in during the public comment period, and so this workgroup it seems would best spend its time working on the first category, the philosophical comments. I think, through the discussion, we can get some clarification out for the second bucket, and then either as individuals, and certainly through our organizations, can provide sort of feedback in the granular items. How does that sound, Tony?

Tony Trenkle – CMS – Director of OESS
Exactly, Paul. I think that's exactly what we need because obviously we're on a very short timeframe, and we want to make sure that we utilize the committee to provide us with the best use of that time, and we don't want to get tied into a whole lot of granular issues when there are some bigger points that really would need to be made.

Deven McGraw - Center for Democracy & Technology – Director
Paul, this is Deven. I just have a question. To the extent that the stage two criteria, you know, you don't have to set – there's quite a bit of a time lag in terms of when those need to be set, and yet some of what we might discuss or recommend are, for example, some things that we didn't get in the first round, but that we want to see prioritized for stage two. Is that on the table?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good question, Deven. We are already on a plan, as you know, to work on stage two and stage three criteria through our series of hearings and through our deliberations. I think that's unaffected. I think today's call really deals with the NPRM, and it mainly dealt with stage one, although it laid out a philosophy for how to deal with stage two and three.

Tony Trenkle – CMS – Director of OESS
That's correct, Paul. We, on purpose, did not get into more specifics on stages two and three, partly because the timing, and partly because of the fact that there will be a number of changes over the next several years, and we're going to insure that as we prepare for two and three, that we have feedback from how the programs are working, and also some additional changes that might occur as a result of some of the ONC funding and other types of infrastructure building that may influence what the stage two and three criteria are.

Deven McGraw - Center for Democracy & Technology – Director
Yes. I don't disagree, and I wouldn't want to open up a broad discussion on stage two since I'm part of this process of thinking about what we're going to recommend specifically for stage two, but to the extent that people may be disappointed or concerned about things that maybe CMS thought were premature to do in stage one, I think it would be helpful to put them in maybe at the parking lot list for ourselves about stage two, and we would be sending, essentially, signals that we think they are pretty serious and ought to be addressed on an earlier stage than waiting until we compiled some specific list.

Tony Trenkle – CMS – Director of OESS
Yes, and I think it's fine to do that, Deven. Obviously they're recommendations, and we can take them under consideration, but I just wanted to make sure we're talking to Paul that we prioritize what the group is going to be doing because there is such a limited timeframe, and we don't want the group debating certain items into the March timeframe because there's a certain we're going to need to move into clearance. And anything that the committee sends to us after a certain period of time is going to be too late for us to consider.

Deven McGraw - Center for Democracy & Technology – Director
Right. I get that. Okay. Thanks.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks, Deven. I think your comments are appropriate. I think what would be most helpful is if we identified a finite and small number of these buckets to sort of … parking lot that we can properly triage these issues to the right buckets, and then deal with them, each one of those. One of the buckets you're talking about is something where you'd like to make a comment. Feedback on the stage one proposal, and also put it on things for further discussion in stage two or three, something like that. How does everybody feel with the comfort level in terms of using this approach of, we'll go through, perhaps, section-by-section maybe? We'll start out with the sort of overall general comments, and then go through, category-by-category, and sort of put issues, enumerate issues and triage them to one of these buckets to just sort of help us with our work plan. Does that seem fair?

Deven McGraw - Center for Democracy & Technology – Director
Yes.

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Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me open it up for a short period of time about just for general comments, philosophies about, or general comments about the overall NPRM and their approach.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine Bechtel. I just want to say that I think it's – I really want to applaud CMS and ONC for the work that they have done. This overall approach to the rule is very pragmatic. I think it's very achievable by a broad array of healthcare providers and practitioners, so I was really pleased to see the approach taken on some of the issues that I know this workgroup talked a lot about and really struggled with, like how do we establish a payment year versus a calendar year, and how do we make sure that providers are incentivized early on to adopt health IT and use it in a meaningful way, but give people the time they need to achieve that status. So I just want to say, I think it's very, very positive. It's a very thoughtful rule.

Deven McGraw - Center for Democracy & Technology – Director
Yes, I would agree with that. This is Deven. It seems self-serving since it really was pretty close to what we had put on the table. So of course we would say good job, but I know it was hard work, and I think, while we may have some issues on some of the details, I think, overall, I certainly was pleased with what I saw.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll also comment that it felt like a very healthy relationship between the ONC, CMS, and the advisory committees to ONC, the policy and standards committee, as well as through all the many outreaches to the public and private sector. It just felt like a good effort with good results. And I think we're in an interation process where we again can make some suggestions, and ONC and CMS can make changes before it publishes its final rule. I think it's been a good iterative process, and it continues to be, and I think we'll try to get the best possible output under all the many constraints.

All right. Why don't we start moving into the individual categories that we helped define? The first one, just for reference if people have the NPRM in front of you, it starts talking about the meaningful use criteria on page 48, it looks like. We talked about the improving quality, safety, efficiency, and reducing health disparity. Just that section, what comments people have, and then we can sort of triage them. We'll start with, and the most important to get out would be the philosophical comments.

In the quiet, I'll mention the clinical quality reporting requirements. People want to comment on that any further at this point before we move it into that bucket?

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine. I'll just say, I have some comments that I'm just totally not sure where they should go, so were we going into clinical quality reporting next, or is that where you think we are now? The rule is so huge, I don't know what our span is here.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good point. The reason I lumped it into this category is that's how it fit into the matrix. You know we had our objectives and then our measures.

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Clinical quality measures in that section of our matrix.

Christine Bechtel - National Partnership for Women & Families – VP
This is an appropriate time to comment on clinical quality measures?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think so.

Christine Bechtel - National Partnership for Women & Families – VP
Okay. So can I just say that there's one thing that is a philosophical approach that I think we took and that actually is reflected on page 48, which is the importance of disparities reduction. But the piece that I

think is not present when it comes down to the practical measures is the stratification of quality measures, or at least the selected set by race, ethnicity, language, or gender.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's an important point. I didn't see that called out.
Neil Calman - Institute for Family Health - President & Cofounder
Yes. It's not mentioned anywhere in the reporting part. It's only mentioned in the collection of data.

Christine Bechtel - National Partnership for Women & Families – VP
Right, and the data collection provisions are great. It's in multiple places, and I think that's fantastic, but it's not in the reporting, and that's a really important piece.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think that's a very good catch. In general, I've noticed what they tried to do is to where they differed from our matrix, they tried to explain that and point that out.

Neil Calman - Institute for Family Health - President & Cofounder
That was not – yes, it wasn't picked up.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It wasn't picked up. Good catch. And I think you accurately portrayed the workgroup and the committee's interest in that because it's really part of that theme.

Tony Trenkle – CMS – Director of OESS
Are we talking about the whole quality reporting area now, Paul?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think so.

Neil Calman - Institute for Family Health - President & Cofounder
One of the things that sort of struck me was in the sort of big table of all of the different quality reporting measures by different, you know, that are relevant to different specialties, that it seems to me that the burden for different specialties is going to be quite different based upon more upon the number of NQF approved measures or, I guess, PQRI measures that are available than any sort of rational basis to say, well, we'd like to have two or three measures for each specialty. So I'm just not sure how that's going to play out. I'm wondering what other people's thoughts are about that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Tony, am I correct that I think I read that the goal was to put out these various tables, but that through public comment, you would try to get them down to three to five in each of these specialty areas?

Tony Trenkle – CMS – Director of OESS
Yes. We're certainly looking. We would certainly try to reduce them, as we get the comments back in. The idea was to put out a suite of specialty measures, and then invite comment in for that.

Neil Calman - Institute for Family Health - President & Cofounder
How are you going to decide based upon? I mean, you're going to sort of tally up what people think are the – I mean, I think there's two ways of looking at these: those that are most readily capturable, but the other way of looking at it are which are the most important in terms of improving the health of the population, which may not really be the ones that are most. So my guess is that the people who are

going to comment are going to say, well, these are the easiest ones to collect. But are those, you know, is there some basis, some evidence basis to decide on the fact that those measures actually are going to be most meaningful in terms of improving the outcomes and health of the population, or are we just looking at which are the easiest ones to collect in each specialty? I'm not sure that the voting or the….

Tony Trenkle – CMS – Director of OESS
We're not going….

Neil Calman - Institute for Family Health - President & Cofounder
I don't mean the voting, but the straw poll kind of thing is going to point us towards those that are most significant rather than those that are easiest to collect.

Tony Trenkle – CMS – Director of OESS
No, we're not going to do a straw poll and base it on the numbers of people who have certain comments. We're going to be looking at the comments as a whole and what they say about the measures and their readiness, and obviously their appropriateness in terms of how they relate to health outcomes, and then make a determination from that. So I think the issue with the quality measures is how do they relate to the overall objectives that we're trying to achieve and, of course, that's one aspect.

The other is what is the operational readiness of some of these measures, and I think you have to kind of weigh both of them, as you look at what we're going to put in for the final publication. But obviously that's something we're going to have to wait and see where different people come in. You're right. A lot of people are going to be looking to say there are too many measures. We need to eliminate a large number of them because of the fact that we can't make these, so that has to be weighed against other factors. So at this point, I can't say where we're going to come out.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

Tony Trenkle – CMS – Director of OESS
And obviously it's not just going to be me making the decision either. We've got to have input from people at HHS and at OMB who have their own thoughts about how this is going to – but I think, in terms of comments, either from the committee or any of you commenting individually, the more you can – I think, Paul, you talked about it the other day, tying the measures to certain themes, showing how if you do one type of measure, it may detract from some of the themes that you might have. I think the more you can tie things together in a certain logical pattern, the more it will make sense to us in terms of whether the – particularly if they're operationally sound. It'll make more sense to us in terms of making final determination on what we need to move ahead with. I guess, is that helpful?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Tony, this is Charlene Underwood. Does that also apply to the hospital measures? Because, again, I think we're in that state with those measures, and again, the scope of them, I think, was really a surprise to a lot of people that they're really not instrumented yet. A lot of the data isn't standardized yet, so it's just like it's a steep bar. So like we'll exactly do what you said. We'll try and look at what are those things that might be feasible to do, but not correlated to what might be best to do because of the scope of what's included in there. Does that process you just discussed, and I agree with the strategy. Also apply to the hospital base…?

Tony Trenkle – CMS – Director of OESS

Yes, and any type of the measures and objectives, as they were changed or modified, I think one of the things that we need from people commenting, whether it's you commenting as the committee or commenting separately, is as I say. This wasn't just done by CMS. There are a lot of people who have their fingerprints on this, and in some cases, it will help in making the final decision if we hear from you or others that there are certain measures that, from a feasibility standpoint, cannot be done in 2011. I think that that type of argument will carry a lot better sway than someone just coming in and saying this is just too much for us to do. We need to kind of back it up with saying this is why we can't do these in 2011. I think that will help in terms of some of the arguments or discussions, rather, that we have internally in CMS with our quality folks, and also as we begin to talk with people at the department at OMB who have very specific thoughts, not only on the quality, but some of the other measures and objectives in the meaningful use matrix.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, just one more comment: I just want to follow on a little bit with that. I think this relates to your theme piece. What is going to be so necessary for the community to be able to respond in these timeframes, and I know this is going to be jumping the gun a little bit on 2013. We really need guidance on that roadmap and the sequence of these things, and we need that guidance that jumps out, looks ahead to 2015 because if we're going to be ready, you know, we can't. The timelines are so tight;, we can't make it. As they're looked at, they've got to be looked at in both frameworks in terms of what makes more sense near term, but also what that glide path looks like.

Tony Trenkle – CMS – Director of OESS
Right. And I also think, from a committee, you need to think about that and, as well, some of the objectives on the matrix because people are going to be pushing. There are some of the recommendations that you've put in that we've adopted or proposed, I should say, not adopted, that there's obviously going to be people from the provider community and the hospital community who are going to give a pretty big pushback. You as a committee need to be prepared also to help defend what you think is necessary in 2011 when you give us the recommendations.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me piggyback on this whole conversation. One, let me address Charlene's most recent comment about the timeline and the glide path. I think that's very important, and as the NPRM points out, they gave themselves a schedule, sort of a due date for the subsequent NPRMs for 2013 and 2015. As an advisory committee, we've sort of moved up our timeline ahead of theirs, so that we can help signal. And I think the whole purpose of signaling is to help with that issue that you described, Charlene, both signals to the vendor community so that they can start developing these things in their system, but also to the provider community, so they can start changing the processes to incorporate that thought. That's point one.

The other thread of the discussion has been around what are the meaningful quality measures. I'll use this point to also mention that the NCVHS, one of our sister FACA groups, had a hearing on meaningful measures. And the goal is really, as Tony was talking about, one of the guiding principals we had as this workgroup in putting together both the overall framework for meaningful use criteria, as well as the quality measures, was to take this moment of opportunity with the incentive program and develop more outcomes oriented quality measures versus what we've been constrained to do in the past, which is process oriented.

Most of us have complained that, gosh, this is only a process when we're trying to get outcomes, and the rationale for that was, well, that's all the data we have. Well, in this moment of opportunity where we are trying to accelerate the development and adoption and effective use of these systems, we should have

measures, quality measures that track the benefits of doing that. It's probably not using the same old measures that were born out of, let's say, the claims administrative data.

One of the reasons we chose the exemplar approach was to say not only should we look at the whole path that I described before, but that also means we should be developing, fast tracking the development of new quality measures that leverage this new, rich source of clinical information, that is the EHRs, and even the PHRs. One of the opportunity costs, I think, if we go back to the existing measures, is not to cease the moment, to transform our measurement systems so that as a necessary path to transform our health delivery system. That's wrapped up in the philosophy of the quality reporting of what quality measures, and the thought would be that we'd have not the old quality measures, but new measures designed specifically for EHRs and the efficient extraction of this data for quality reporting. Does that make sense?

David Lansky – Pacific Business Group on Health – President & CEO
Paul, it's David. I want to piggyback on that thought because I think that's really well said and very important for us. It raises the difficulty at this stage. Part of my reaction to Neil's question about the criteria for CMS and ONCDUs in thinning the deck of measures is we got into this whole quality measurement business not primarily at this phase of the evolution of this process to drive improvement in quality, but to have the eligible providers demonstrate that they are implementing the technology in a way, which permits them to drive improvements in quality.

In a sense, I feel like we need a set of tracers or markers in the measurement portfolio, and I don't know what they are. And maybe it's sort of departmental or functional or data typology based, but if I were thinning the deck of the laundry list of measures that's now listed by specialty or by provider type, I would want to pick a small number of measures, which reflect competencies or functional capabilities, whether it's clinical decision support, content, content needed for clinical support, or measuring of biometrics that are otherwise not captured through other data systems, or capturing of the diagnostic and judgment information that's otherwise not captured through like a problem list through these systems.

But somehow – so rather than multiply or even decide how many process measures we need, I think we need a typology or we would encourage CMS to use some kind of a framework that said have you got at least one measure that is a measure of diagnostic and cognitive data? Have you got at least one measure that is an objective, biometric measure, etc.? I don't know what that framework is, but I feel like we're missing something here in trying to drive adoption of a high performing technology in terms of these criteria.

I'm like you. I don't want to see us have 20 process measures for cardiology and 17 process measures for endocrinology. I don't think – there are other organizations fighting that battle. What we should be doing is testing whether the technology is going in the right direction.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Very well said. Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. I agree with David, and we have to be careful that the goal is not quality measurements. The goal is quality. Often when you have concrete quality measures, especially, as he said, the old fashioned ones, you can achieve those in different ways. One way is to improve quality, but another way is to just achieve the quality measures sometimes at the expense of other forms of quality. So, in general, I'd like to see the use of EHRs promote quality across the practice. One way to look at that, one view of that is

quality measurement, but it's not the only one. And I would hate for the entire project to feel like it's merely an NQF quality measurement project.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well said. I think there have been excellent comments. Let me use this opportunity to try to show. This is the kind of discussion that we should have in the future, and then come up with, so for example, David gave a very precise, concrete suggestion. Create a typology for quality measures, and … what George just said about it. It's not all about the measures. We've gotten even a better surrogate, but we need to really know how we get improved outcomes. But that's exactly the kind of discussion we should have in our ensuing calls in the next month before the February meeting. To finish the job for today, we need to pick up these topics and, clearly, clinical quality reporting, the quality measures, and the tie to outcomes improvement is one of those big topics. What are some of these other philosophical topics embedded in the changes of the NPRM, the proposal in the NPRM, and perhaps some of the changes from our recommendations?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Are progress notes in this section?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Progress notes are in this section, which means it's not in this section.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
They are no longer in this section.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right, they're not longer, so you think that's a philosophical?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I think so.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think a lot of us do.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Well, problem notes and the other one….

Neil Calman - Institute for Family Health - President & Cofounder
Progress notes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Progress notes, as well as the bar for problem lists.

Neil Calman - Institute for Family Health - President & Cofounder
Yes, so can we--?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's another—

Neil Calman - Institute for Family Health - President & Cofounder
Do you want some rationale for some of these things that--?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we'll save that. I think, I mean, the fact that unanimously everybody is saying or missing progress notes, we'll certainly discuss that well and probably come up with a rationale very quickly on that call, so that definitely is in that bucket. Another one that somebody just raised is problem lists.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The bar for problem lists, especially in hospitals.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
I would agree, and I don't know which way you're going Charlene.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
To me, I think what our criteria, our matrix said was to maintain an up to date problem list, med list, and allergy list, and the NPRM has none or one or more, and it wasn't clear exactly, do you have to maintain it up to date, or is it just it has to be present. And so one philosophical is this whole notion of up to date maintenance of something versus a one-time act. I think that's a theme that is in many of these….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I was talking with our customers on some of these issues, and again, and I don't know how this falls under the category, but I think everyone gets the intension. It's almost like everyone gets the intention of what the policy committee wanted to do, but the operationalization of that is really challenging. Do I have to meet 2013 criteria? What if I'm, because of the time, make good progress, but don't meet all of them, and some of the bars are very high? So it's just the cumulative effect of trying to do all of them in the timeline, in the stages is really a challenge for a lot of our customers, and getting absolutely no credit, and then the acceleration of having to be done and the penalties, so that whole bucket of stuff, that conversation, and the feedback. We need some more flexibility because we don't want to stop them from doing anything. We want them to make progress, yet the cumulative effect of meeting 80% of a problem list in a hospital, which is a major change, etc., it's just a lot.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Can I label that issue as the all or none issue?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Actually, that was the flexibility issue was a key. That netted it out. But the detail behind it, you can detail every one.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Can I ask a question?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, please.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
This is George. Take progress notes for example. What is the mechanism for us to find out, I guess really for Tony, what the thought process? There's no sense in us waxing poetic about any of these issues if the pressures that cause the change are still there, and we don't know what they are, and we don't address them.

Tony Trenkle – CMS – Director of OESS
Yes, we can only go far on that, George. I mean, obviously the best way – I can't get into who had this as their priority to put into the regulation. We can only say, here's the regulation. Here's how we explain what we did, and if our rationale is something that you want to question, then you put that into the comments. I can't say what the feeling is behind that or who was behind it. But I think, if we receive comments from the committee and others that question it, as we were just talking about the all or none issue, and the flexibility, that's the type of stuff that allows us to either rethink it if it's a CMS perspective, or if it's someone from the department or OMB. We can go back to them and say, we may need to modify this particular criteria because these are what we're getting in from the community.

If you looked at our final regulations in other venues, that's what we try to do. We look at the comments, and then we have a discussion about the comments, and then we come up with what we think is the solution based on what we perceived. But beyond that, I can't shed additional light behind some of the decisions that were made on what was put into the NPRM because we just can't do that.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
All right. Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
With respect to progress notes, George, they did offer a rationale. I mean, the statement was that it didn't impact coordination of care. I'm just paraphrasing it. I thin we can go back and say there are a lot of folks that do think it does, and so we would be doing what Tony said, which is comment on the rationale, the written rationale for them dropping it.

Tony Trenkle – CMS – Director of OESS
And not just saying that we think it does impact, but why you think it impacts.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. We would offer that, but there's a specific comment, and we can give feedback on the rationale and provide our evidence as well.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I don't want to get into the discussion, but let me ask the question because it affects several of the areas. Is there, because I actually don't know where to look this up. For order entry, a doctor has to actually use the system, I believe, it says. But for the other areas, you could have an intermediary using the computer. Is that correct?

Neil Calman - Institute for Family Health - President & Cofounder

For what? What do you mean? For what kind of area?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Like entering the problem list. You could do it on paper and have your nurse enter it.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, but the issue with that, and I'm going to – I asked that question here, at least in the inpatient. Because it needs to be codified and ICD-9 or SNOMED, that implies the use of a physician doing that, so it won't work for a nurse to do it, or it's got to be done from your coding system after the fact, which contradicts the timely stuff, so once you link it to the standards, then it gets more complex.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Okay. So I guess my general comment is to what extent, but I'm just thinking right now, after the discussion we've had about quality and progress notes and the problem list, is the issue is to what extent is the doctor using the system versus to what extent is an intermediary using it, and how does that affect the whole thing?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. That's a great theme.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I think, for order entry, the doctor has to be using it, and I don't even know if that's true. But for everything else, and then that then affects what you think meaningful use is.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Tony, is it explicit in the NPRM, because I guess I still have George's question as well. Is it explicit that these are doctor entered or whoever is doing the actual … whoever is responsible for the legal entry is doing the entry? Is that explicit?

Tony Trenkle – CMS – Director of OESS
I'd have to go back and read that and see what the kind of interpretation is. I mean, obviously if someone's attesting that they did something, they would be the people who would be thought to be doing the actual activity. But whether it specifically says that in the reg, I'd have to go back and take a look at what it says. I understand the question. I'm struggling with having to go back and read over it. But once again, this might be a comment that—

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
A verification.

Tony Trenkle – CMS – Director of OESS
Yes, that where it lacks clarity and you think it can create an impact in terms of meeting the meaningful use or creating a situation when there's an audit that it will create a problem. I think that's where you need to make it clear in your comments that that's something that needs more clarity.

Neil Calman - Institute for Family Health - President & Cofounder
So we would want to specify that it's not – are we – I'm not sure what side of this we're on, but we would want to specify that it's not necessarily the physician, right?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Actually, Tony, one of the things on that end, the original matrix, like for CPOE, it said had to be entered by an MD, but then in the objective, it was MD, nurse, licensed practitioner. It was more vague.

Tony Trenkle – CMS – Director of OESS
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think the customer recommendation, we talked about that, was a licensed professional or some term like that, which is licensed professional, because sometimes nurses can't enter. They use CPOE, but a nurse could really use CPOE, right?

Tony Trenkle – CMS – Director of OESS
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's not the intention, so the recommendation, at least from the customers, is they said, well, we use licensed professional, so some wording like that would clarify it.

Tony Trenkle – CMS – Director of OESS
Okay. That makes sense. I think that's – once again, as I say, that would be good for someone to….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, we'll send that in as a comment, but I think there's a lot of confusion because, okay, well, I can get this 10% with my nursing staff. Right? Well, that's not the intention either.

Tony Trenkle – CMS – Director of OESS
Right. Exactly.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Tony, you also use the word audit here, and in the first year, it would be an attestation. Is it your intent that there may be random audits to follow up on the attestations?

Tony Trenkle – CMS – Director of OESS
Yes. Well, we're still working out the audit protocols, but there would certainly be, at some level, some random onsite audits, but we're still working that out internally how we want to do some of that. I mean, we've got some ideas, but we haven't finalized it, and we say in the reg that we're going to be doing audits, and we'll be getting more specific as time goes on.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. Other philosophical comments? These have all been excellent and appropriate.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine Bechtel. On page 59 of the draft rule, CMS essentially proposes not to provide patient specific education resources … include that objective, and I think the philosophical issue – that may be a granular issue in some people's minds, but in my mind, there's a philosophical issue, which is the assumption for not including that is that you have to have somehow those education materials built into the EHR. And I don't think that's the right assumption.

I think that there – and I also think it doesn't reflect the right understanding, but – so I'd like to put that on the list to talk about how we can provide. I think the rule does a good job of providing access and copy to information, but if there is no context, then patients are going to be even more confused, and the providers will be further burdened by patients calling and saying, I don't understand what this means. What does this mean? I think the assumption and the philosophical issue is how we ramp that up in a way that works and is reasonable expectation for the first stage of meaningful use.

Neil Calman - Institute for Family Health - President & Cofounder
Right. This is Neil. I would second that and also say that the requirement that it be integrated into an EHR isn't really what we're interested in.

Christine Bechtel - National Partnership for Women & Families – VP
Right.

Neil Calman - Institute for Family Health - President & Cofounder
What we're really interested in is using technology to be able to do this for people, so if people have access to MedlinePlus through their office desktop computer, and they can print relevant information for people, that's clearly available now to be able to be done. And also, there are many systems and many ways in which these things are actively available within EHRs, so I think that there was some thought there that this stuff is not available at the current time, and I don't think that's correct either.

Christine Bechtel - National Partnership for Women & Families – VP
Right, and I agree with Neil 100%, and I think the philosophical issue is that we can provide multiple ways to achieve this particular objective, which is what, you know, right, you have, there is absolutely a role for an EHR. And it could be that the resources are integrated, but it doesn't have to be. The role of the EHR at the core is to provide the contextual information that the human can interpret and then say, okay, let me point you to some other electronic education resources so that when I give you access or a copy, you get what I'm giving you, and it's meaningful and actionable.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And the other philosophical comment is part of the rationale for eliminating it was, well, it would be really hard to account for everything from language to literacy, etc. I think that fits in the perfect meaning….

Neil Calman - Institute for Family Health - President & Cofounder
Right. Definitely.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We really do need to – there are a lot of things we can get out now, so we should start with that.

Christine Bechtel - National Partnership for Women & Families – VP
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And build, and continue to build, and perhaps in the later stages, those become more meaningful to a broader section of the population, so we've said it. Another area is reminders, and I think there may have been a misinterpretation here. It cut it down to – it sounded like I cut it down to only people over 50, and you would give a generic reminder saying don't forget, you know, health maintenance kinds of things. I believe our intent was that you would – the clinicians, the people using the EHR would be reminded by the system for patients with patient specific reminders. So this patient at this age with this risk is in need

of the following, and it wasn't an electronic postcard, so to speak, and I think that's how it read. I may have misinterpreted their interpretation, but that's….

Christine Bechtel - National Partnership for Women & Families – VP
Paul, I'm not sure I'm following you. I think this was patient reminders, not reminders to the doctor that a patient needs something.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. I guess those are two sides of the same coin, so part of the ways you reminder people, so you can remind the doctor to remind the patient. But there's been plenty of evidence that when you remind patients, it works even better. But the whole process is when you give specific reminders that apply to specific patients rather than a general, get your things over 50. And that's how the – I'm trying to find that item – that's how it came across to me when they limited it to just over 50 years old.

Christine Bechtel - National Partnership for Women & Families – VP
Yes, it's on page 84 and 85, and I agree, but from a women's organization, I have to say that women need a lot more regular, ongoing, preventive and different kinds of care, and so this was a big issue for me in terms of limiting any kind of reminders to patients 50+, I don't think make sense. So I think you're right to flag it. I agree, and perhaps we can think through what a stronger recommendation might be that is feasible and yet not overly burdensome.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Great. Okay. Other global comments?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
One of the areas I wanted to bring up was continuity of care kind of as a theme, and there are two pieces of that I wanted to bring up. One was, and there's a lot of, and I'm sure Tony is going to hear this, confusion about the definition of eligible professionals in the ambulatory environment, and do they qualify for the incentive or not? In talking that through, again, that definition isn't exactly clear, and there's a lot of debate out on that. Maybe Tony can add some clearance, but assuming that eligible professionals, for instance, those physicians who are primary care practices that are affiliated with a hospital do not qualify. This is flagged in the rule as a gap.

The issue that comes to the table is not only the funding issue that they can't fund them, but the bigger issue is that, as we look at moving to an integrated model, it really would make more sense to harmonize and balance the uptake of EHRs kind of across those environments and connect them in a consistent way as one issue. Another issue is that if you have a hybrid model, there's lots of inefficiency and variation, etc. I'd like to put that issue on the table in terms of the definition of hospital based eligible professionals and get clarity on what that is, and see what the implications are to achieving continuity of care.

The other piece in that goes, there was a new requirement added to share care summaries on a referral, where before we were kind of … the capability and the testing of that. So it seemed to contradict what we were trying to do in our other definitions, which was to make sure that the providers weren't held accountable for making sure they had something to connect to in the early phases, and get them ready to do that in the next phase, so I think all of that links together.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It looks like we've skipped into – have we exhausted the ones that come to mind anyway for the first category, the quality and safety efficiency disparities?

Christine Bechtel - National Partnership for Women & Families – VP
I think that's where the advanced directives piece is though. Is that right, Paul? Do you want to save that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That is correct. You wanted to raise that? That was eliminated, and you want to raise that as a discussion point?

Christine Bechtel - National Partnership for Women & Families – VP
I think so, for later, because I think it's important, but if I had to guess the reasons, given the public debate last summer, I think I probably understand, but I'm not sure that that's the right answer when you talk to geriatricians who say, look, this is really important and really helpful. So I think it's something to keep thinking about.

Deven McGraw - Center for Democracy & Technology – Director
Yes. I mean, I read that. This is Deven. I read the rationale in the rule, and I get it that certainly it's not one that's crosscutting across all patient populations, particularly necessarily in the pediatric context where you're talking about healthy kids. But I'd like to do some more thinking about it too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Especially considering this is Medicare and Medicaid, and clearly all the Medicare should have an AD. And likewise for … pediatric things, which apply to very few people in this target group, I mean, that would be inconsistent with taking something out just because it didn't apply to everybody.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Christine Bechtel - National Partnership for Women & Families – VP
Right, and we have the reminders were already targeted at age 50+, so there's clearly signal the willingness to do this.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Anything else in the first category?

Christine Bechtel - National Partnership for Women & Families – VP
I have one thing, which was something to flag, and it's definitely philosophical, which is how can or will CMS be able to give feedback to physicians and clinicians once they've submitted their quality reports? It would be great if they could then see how they compared to their peers in their region or nationally. You know, how are they improving over time? But something that makes it be a two-way street so that clinicians can submit, but then they can also learn and understand back what their data really means.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. I'm sort of assuming that's in their plan, looking at hospital compare, etc.

Tony Trenkle – CMS – Director of OESS
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It might be safe to assume that that's in the plan.

Christine Bechtel - National Partnership for Women & Families – VP
Great.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's move on to – and of course, this is not the last chance to provide feedback, but let's move on the patient and family engagement. One of the things was the whole access to their information, and CMS did add some parameters like 96 hours and 48 hours. It might be in the detail, sort of both the logistical from the provider, as well as the system detail, but 48 hours doesn't include a weekend, that kind of thing. But it almost looks like when you add that kind of timeliness factor and the percent of people that should have access, you're almost, by default, talking about sort of Web based access versus these other examples of CD and USB.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
…specific?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
I'm not sure of it. I mean, I think it could be available, I guess, on USB or something like that if patients want it. But the idea wasn't to try to dictate the format except to say electronic, of course, as much as to be flexible for patients who may, for example, it's probably easier in some ways for a patient to take a copy with them to another provider if it's on a USB or a CD versus access to information so that I can see and manage my health for my own purposes on an ongoing basis.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And we had considered that, which is why we had put some of those e.g.s in there as well, but once you add the timeliness, then can you see getting your lab tests on a CD to a patient within that time, 48 or 96 hours?

Deven McGraw - Center for Democracy & Technology – Director
If you can do it electronically on a portal, why couldn't you just copy it on a CD?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, but somebody has to….

Neil Calman - Institute for Family Health - President & Cofounder
By request, you have to either mail it to them, or they have to be present in the office to get it. That's the problem.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right. I think that's valid. The other point on that one, like the measure, and again, I'm not quite sure. We don't have the proposed alternative, but as you look at the process, how are you going to keep track? How are you going to get the denominator is the question on that one, and do I have to have a manual process in place to measure those people or build it into the system, that request, and don't get their copy

to get my denominator, so that's a challenge, and that's a burden on the workflow and the current offices and hospitals.

Christine Bechtel - National Partnership for Women & Families – VP
What's a good solution? I mean, I'd rather be in the position of suggesting solutions than raising a problem with it.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. I have to actually – I told our customers the same thing. We'd come back and ask for solutions.

Deven McGraw - Center for Democracy & Technology – Director
This is Deven. I'd prefer to sort of look at the timelines and think about a way to work with them. So for example, rather than saying that the patient had to get the electronic copy in a certain hourly timeframe, they have to be—

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Available.

Deven McGraw - Center for Democracy & Technology – Director
…within that timeframe that the copy is available, and then the provider can make appropriate arrangements per the patient's preference on how they want to get it. Then, of course, if they've got an automatic download into a PHR, they can check that box off really easily. I don't have a good answer for the denominator issue. I think it's a good question.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's move that into that discussion, so that topic is registered, and that's the kind of thing, and I like the idea of when we do bring up an alternative, and when we do bring up an issue, we should, in our recommendations, have an alternative and a rationale. That's the most helpful, I think, to CMS.

Deven McGraw - Center for Democracy & Technology – Director
Yes, and the access measure is only 10%, so realistic here.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Christine Bechtel - National Partnership for Women & Families – VP
We just still have to know what 10% of what is.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The denominator.

Christine Bechtel - National Partnership for Women & Families – VP
Right. I got that. I think the timeliness stuff is really good though, as Deven pointed out. I agree.

Deven McGraw - Center for Democracy & Technology – Director
Yes. One of the more exciting things.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. I think that there probably will remain some confusion between access and copy, so I think anything that we can do to kind of continue to clarify our interpretation of that because both are very important would be good.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Exactly. Another area, and I think this is something we did not spend enough time on, we used the term relevant encounters. I don't think that the informal definition, the way we discussed it on our call is the same as what's written in the NPRM, so I think we need to take the responsibility to be more explicit in what we meant by relevant encounters.

Christine Bechtel - National Partnership for Women & Families – VP
The other thing in this area that I had was just noting that for eligible providers, if there's suggestions to provide clinical summaries to patients for each office visit, but when you look at the corresponding metric in the hospital setting is a discharge summary electronically upon request. I'm not sure I understand the rationale for that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think upon request is almost the patient preference piece, so does everyone want it electronically, or do they want a paper discharge.

Neil Calman - Institute for Family Health - President & Cofounder
Well, it's also a question of whether or not people should have access in some way to their record while they're in the hospital.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
This is my interpretation of kind of what we said. We were trying to deal with the problem like in the early stage that they might not have a place to send the discharge summary to. Likewise, the practice might not have a place to send the referrals, so at least in the meantime, the patient could be the person, could be the HIE, if you will.

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
So the intent was like if that happens, at least in the early phases, we'd be able to produce an electronic copy of their record so that they could carry it to the next place, and then as the HIEs started to build up by 2013, then we could transfer it, and I think the same thing would apply to the clinical summaries with kind of the same intention there. At least I thought that was our intention, so you wanted at least the means to be able to do it, and so those advanced places could do it, but at least the bulk would at least start to have something electronic in that time window.

Christine Bechtel - National Partnership for Women & Families – VP
Right, but I think I'm saying something even more basic, Charlene, which is that it should mirror the EP measure, which says clinical summary, so discharge summaries provided to patients for at least 80% of all discharges as opposed to summaries provided upon request.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
They should or shouldn't?

Christine Bechtel - National Partnership for Women & Families – VP
Should. It should be….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Yes, I'm with you.

Neil Calman - Institute for Family Health - President & Cofounder
My question about this though is, what about access to that information during hospitalization, which right now people have no access to, but frequently want?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I would agree that they frequently want. It's not; it's by no means widely available in the commercial products, and we didn't include that on our criteria, not that we can't in future stages, for example.

Neil Calman - Institute for Family Health - President & Cofounder
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Are we ready to move on to the next category?

Art Davidson - Public Health Informatics at Denver Public Health – Director
Paul, this is Art.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
I'm sorry. I was trying to make a comment, but I was not allowed to speak. I had to call back in. It's actually on the first item. It was around – we had some comments about generic lists of medications that seems to have fallen off the meaningful use criteria. I didn't know what happened with that use of generic names.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good point.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Actually….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's another one where it's just an oversight probably. They didn't point out that that was missing, so thank you for bringing that up.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That was one of our efficiency quality costs kind of a thing.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Right. Thanks.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you. Which reminds me then, that means that probably the imaging indication was also dropped.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Did it? Was that for 2011?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think so … figure that out.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I've got my other piece of paper.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, it was.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, it's David. I'm sorry. I'm going to have to drop off here shortly, but it does seem like the efficiency area is one that deserves to be on our philosophy list. If the efficiency measures are proved, and maybe Tony can comment, if they prove to be difficult to include mechanically or otherwise, we should understand that to try to discuss how to make sure we address that theme somehow going forward.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, both generic and the indications for high cost imaging were measures for 2011, so we should get back to it. Some of these probably, Tony, you might be writing down that we can get follow up on rationale where available, I guess.

Tony Trenkle – CMS – Director of OESS
Yes. I think that's fair.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Moving on to care coordination, clearly the biggest difference here was adding the tested once criteria. Now what's not clear, and it may be just as simple as a clarification. Tested once with the actual recipient agency where that exists for just testing your software. For example, testing the communication with an immunization registry, does the test have to involve the public immunization registry, and does that exist everywhere, that kind of thing … labs, etc.? That may be a clarification question. And, if not, it may turn into a feasibility question.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
What was the qualifier about, unless none of the public health agencies are capable of receiving it, right?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, you can certainly imagine, let's say, a big state like California could be capable in principal of receiving it, but would they want to deal with the, I don't know, maybe thousands of practices doing their tests?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
How are we ever going to get the public health agencies to get onboard with this?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
When they're accessing it through the NHIN … because right now, without the NHIN or however things are going to be moving around, it would be difficult to have all these peer-to-peer connections and tests.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I see. But that should be something that ONC considers, as it moves forward with the NHIN, how that will impact on our capacity to make these 2011 measures work.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. Exactly. So if there was one place where you could test it, that's fine. I'm not, well….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I mean, like, if we had a NIST infrastructure and could just test against that and get our checkmark, we could do that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. Exactly. That's sort of a software test through the vendor, for example.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right, or it could be at a provider site too, but it's, you know, something like that would help us.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's a topic. They did add this new summary care record for transitions of care and referrals.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, before we go there, I'm not sure if it's before or after, but I want to raise something that is on page 95, which is the test to electronically exchange key clinical information. That is, it's a philosophical question. I think that this section assumes that, and it says the infrastructure necessary to support exchange is still being developed, and I think it assumes that you need HIEs or an NHIN or something like that. And I guess I'm philosophically sort of wondering here, what about other ways that you could exchange key clinical information like secure e-mail or other things? I mean, do we want to be open to that, or is it only test connection to an HIE?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I don't think this is specific, actually, so it does not rule out what you said.

Christine Bechtel - National Partnership for Women & Families – VP
Right. So if that's the case, then could this requirement be more robust than just one?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Which one?

Christine Bechtel - National Partnership for Women & Families – VP
I'm on page 95, and it's the EP eligible hospital measure that says performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. And it really says the capability to send, and that probably should be send and receive. And the infrastructure is still being developed, and that catch phrase makes me think that the assumption here is you need a network or something like that. I'm not sure that secure e-mail wouldn't do the trick here in 2011 at least.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think the biggest issue that came from the provider side of the market, if they're going to be accountable for this one, they had to know, like, there are some places, a lot of places where HIEs don't exist and/or

physician practices aren't automated. So at least in 2011, because they're trying to get these practices up, they didn't want to be held to having to be accountable for something they can't control. So that was, I think, why it was a capability, and whether it's one or several tests, I think they could definitely do the test, but to do the exchange in 2011 was the challenge.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's just – we do have this on the discuss list.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, this is the other one. I don't know if we can talk about the clarification of the outpatient eligible provider piece with this, but this is, again, the broader context. You could say it's just financial, but it's really continuity of care too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What is really continuity of care?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Again, this is, are eligible … for instance, those who – and again, it's not who are employed in the rule, but who use facilities of a hospital are excluded from receiving the incentive. And the rule really talks about they're concerned about the outpatient environment. Our customers are concerned too because what that says is they were counting on some of the funding to automate it, but to do just the inpatient without the outpatient doesn't allow them to grow electronically consistently across their organization. And they feel there'll be gaps in quality and continuity.

Christine Bechtel - National Partnership for Women & Families – VP
Charlene, can they utilize the stark exception to grant those physicians?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
If these hospitals had two nickels to rub together and could give them some money.

Christine Bechtel - National Partnership for Women & Families – VP
…right?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right, they need some money.

Deven McGraw - Center for Democracy & Technology – Director
Well, and it's not just that. This is Deven. It's that there are ambulatory docs essentially who won't be required to meet any of these meaningful use criteria.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's the other side of it. Yes. They had a hammer, and they don't have one anymore. I didn't even go there, but it was like, and there's hundreds of these practices out there.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's very true.
Deven McGraw - Center for Democracy & Technology – Director
Yes, especially in the primary care world where many of them have sold their practices, but are still really operating in an ambulatory setting.

Neil Calman - Institute for Family Health - President & Cofounder
One of the problems I think we would have though is that in many cases the clinics or the outpatient departments would probably qualify under Medicaid more than under Medicare, while the inpatient side might qualify under Medicare. You might end up with some discrepancy there. …outpatient systems—

Deven McGraw - Center for Democracy & Technology – Director
…applying only as a hospital, they get to dip into both pools.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right, but … probably just one or two of the pools, they won't qualify because they are using the hospital facilities, but they would have to just be one or the other pool, but they can switch. There's a lot of flexibility in there to move from one to the other.

Neil Calman - Institute for Family Health - President & Cofounder
Yes, one time.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. And, I mean, so you could just get – the first year, you could see them getting up and running, and getting money from Medicare and Medicaid, and then switching to Medicare. I mean, it's complex, but it's doable.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This is clearly an enormous topic. Tony, was it CMS's impression that the statute required this interpretation?

Tony Trenkle – CMS – Director of OESS
There are a lot of complexities to this, and we have certainly heard from a million hospital groups, not one clinic, but many hospital groups. I'll put it that way. But we have been limited in some ways by the statute. We have attempted to be as liberal as possible in interpretation. As we say 90% substantial, 90% is pretty substantial, and we also point out in the regulation that people have identified themselves in a certain category and have actually received higher payments because they identified themselves at a certain category over the years. Now, for the purposes of meaningful use, they want to change themselves to a different category.

And there are also issues that deal with regional or local versus national. What may be an issue in the Bronx may be somewhat different in other parts of the country. And so we heard from the different groups. We tried to craft it as much as possible trying to bring in the broadest number of, you know, eligible professionals as possible. But, at the same time, not putting something in that would create bigger operational issues, and also create conflicts with our other programs.

What we've done is put out there a proposal, and we've asked people to come back in with data and other supporting evidence that will potentially allow us to change the definition if the rationale is there. It's a very difficult issue. As you can imagine, we've heard from every hospital group in the country about this before it came out. But we do have certain limitations, some programmatic, some statutory. And, frankly, there is also a thought that maybe in latter years, it needs to be part of the meaningful use for the hospitals as well as a criteria because there does need to be an integration.

We don't want to do something that's going to hurt the integration, but we have to come up with something that makes sense on a national basis, not something that we have every group in the country coming in asking for an exception to. So we're trying to find a middle ground, and to the extent people

can help us do that, and the extent that we have changes that we can make that don't undermine other programs, I mean, we're certainly open to hearing them. But it's been a very tough middle of the road approach to try to take, but that's why we went with the 90%.

Christine Bechtel - National Partnership for Women & Families – VP
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Tony Trenkle – CMS – Director of OESS
Because 90% is pretty substantial, and … utilizing one category to get additional payments under other programs, and now they want to be something else for this program, so it's not an easy answer.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, it isn't. Tony, would you expect to be participating on our calls over this next month to help iron some of these things out and, in particular, this depends so much on knowing some of the constraints, so that we can be as helpful as we can to try to propose some kinds of alternatives with rationale?

Tony Trenkle – CMS – Director of OESS
Yes, I can, as much as possible, be on the calls, and we can certainly have people from our payment policy group also participate as needed. Obviously there's only so much we can say at this point because we've put out a position in the rule, but we are certainly open to hearing solutions that will help promote adoption and meaningful use. We don't want to take away from that.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Tony, one of the surprises we had, we interpreted from the rule then that therefore in the denominator. This is a positive and a negative, actually. We had a big debate on this one. It excludes now order entry through the emergency department from being counted because it's considered one of these other points of service.

Tony Trenkle – CMS – Director of OESS
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Again, we had the huge debate by our customers. Some of them wanted to include it, but it expands the number of the denominator, so others didn't want to include it. So we could certainly see some of the dilemma that you're in.

Tony Trenkle – CMS – Director of OESS
Yes, we're trying to develop consistency here. We're trying to make things as wide open as possible, so we can get the largest number of … because it's a balance. It's really is.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think, from this workgroup and committee's perspective, our emphasis would focus a lot on the meaningful use piece. In other words, some of the inadvertent impediments to integrating both data and the care process, so I think that may be a perspective we'll try to work on. But clearly it's a big deal, and I think we should devote a fair amount of time to it. That particular discussion will be useful to have or

allow CMS input … on all those constraints that we need to incorporate as well. Just like somebody else mentioned … come up with a solution … constraint just doesn't allow.

Okay. Very good. Other comments in this particular – this is the care coordination, and then we'll move on to the privacy, which has changed fairly substantially.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Paul, just one more question on both med rec, and we talked about the care summary. The med rec piece, it doesn't seem like the interpretation of what was put in the rule followed what we talked about because it seemed like in 2011, we really looked at med rec, for instance, at the point of admission or the point of discharge. As we read it now, it could imply every care transition, so you would say, okay, when I'm transferring you from ICU down to step down to, you know, whatever, I think we're going to need some more – you know, we need to decide do we want to go back to where we were. I think it just – the translation may not have occurred in the way that we intended it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You're saying we did not intend to go from, when it goes from, when you're transferred from one unit to another?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, I thought the intension was we would do reconciliation in stage one at, for instance, when you're admitted or at the points of transfer between physical entities as opposed to each stage of transfer within a facility.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I remember us having a little difficulty in trying to separate the two, but that's….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I know.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
…discussion.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It really raises the bar a lot to go to the whole thing in 2011. That's all.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The same for relevant encounters, as a provider, we should put a more precise definition in what we recommend back. We did not do that initially.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Are we ready for the privacy piece?

Deven McGraw - Center for Democracy & Technology – Director
Sure.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's not to call directly on you, Deven.

Deven McGraw - Center for Democracy & Technology – Director
No, I know. Yes. You know, I was pleased to see the security, that the security assessment stayed in there, especially given the testimony that some of us may have heard at the standards committee had a daylong hearing on security. And essentially there is, at least based on some surveys that have come out from HIMSS and others, an indication that the healthcare sector in particular has vast room for improvement on the security side, and this is one of those areas where the technology can actually move you forward through capabilities that can be built directly into these systems, so I was glad to see that on there.

I think I wondered what the measures should be in terms of this risk assessment. Is it just an attestation that you did one? Is it also an attestation that you made the corrections that were recommended, and that you felt were appropriate? I think it's a little bit unclear, and I'd love to see some more clarity there.

On the compliance with the nationwide data-sharing framework, it's noticeable by its absence on the one hand. On the other hand, what's in that framework is really more at the principal level. So I think it's very hard, understandably, for providers to know exactly what they need to do to comply with something that's, again, really at a principal level and doesn't contain a lot of details. One could argue that if you are in compliance with HIPAA, you're essentially in compliance with that framework because there are increments of HIPAA that fit in with those principals. I understood why that didn't make it in.

I think, on the privacy rule compliance and sort of not picking up on our recommendation, the people who are under sort of an active, formal investigation versus just a complaint stage, you know, personally disappointed there. It's something, now we actually have a privacy and security workgroup, which we didn't have when we first came up with this matrix. I know we're going to be discussing it in some more detail on our call on Monday. I think I still wonder why we would, particularly if an entity is actually potentially going to be fined civilly for a HIPAA violation, why we would allow moneys to go out of the Treasury for meaningful use when they're having a clear problem on the privacy end. I don't know if others feel the same, but those were my general impressions. Again, this is also, now that we have a privacy and security workgroup, we are going to be discussing these, so I guess there's sort of some cross-jurisdiction now that we have the workgroup established.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we can certainly invite your new workgroup, particularly with your next call, to formulate something to bring back to their workgroup as far as dealing with this category.

Deven McGraw - Center for Democracy & Technology – Director
Yes, we'd be happy to. And since you're on it, Paul, you'll be in those discussions too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And you. Is it the intent, Tony, that if you were in full compliance with HIPAA security that you would meet this objective?

Tony Trenkle – CMS – Director of OESS
Well, I guess it depends on how somebody interprets that, but certainly risk assessments are part of that security rule, I mean, so I think you could interpret it that way. Yes. I don't want to make a blanket statement because the only thing we're requiring as a measure is the risk assessment when there's more to the security rule than that.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Tony Trenkle – CMS – Director of OESS
But it's certainly a critical part of the security rule.

Deven McGraw - Center for Democracy & Technology – Director
And one that, again, based on survey data, a lot of providers, notwithstanding the requirement, don't get to.

Tony Trenkle – CMS – Director of OESS
Exactly.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
You know, for a large, complex medical, I mean, if we really carry out the execution well, then most medical centers should be being fined every year small amounts for things that are going to go wrong and you can't stop.

Deven McGraw - Center for Democracy & Technology – Director
But that's not necessarily true. Is that George?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Because I can see, my faculty members are in charge of an $8 billion corporation's security, and you just can't stop that ten-thousandth person from giving away a social security number of something, and you act appropriately, and you report it to the state prosecutor, and you do all those things, but that's going to happen on an ongoing basis to every large center. I think a small practice don't expect many fines to occur.

And so I'm not sure that the – I don't know that we should link those … I mean, it's two very difficult things, meaningful use and privacy and security, and have mechanisms for both. I don't know that we should do that. We're not going to say that you're not in compliance with HIPAA if you don't do meaningful use. I don't think we should have not meaningful use if you're not in compliance. Well, I don't know. I don't want to go that far. I'm agreeing with you to some degree, but I don't want to go too far.

Christine Bechtel - National Partnership for Women & Families – VP
Yes, George. This is Christine. I don't want to go that far either, so I think it's important to let Deven's workgroup do some things. I think, at a minimum, we need to talk about the importance of the security assessment, given the wild number of healthcare organizations who don't do the required annual security assessment. Then let Deven and her group come up with some things because I think you can't be meaningfully using an EHR if you're not protecting patient information.

Deven McGraw - Center for Democracy & Technology – Director
Yes, and we have a good cross-section of people as well in terms of sort of providers being well represented. We have health plans represented on the call. So it's not as though there aren't people who understand that incidents happen every day, and that we would want to craft a solution that would, I think, send a message, but also be reasonable and appropriate.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair

That's it. Thank you. That clarifies it. Incidents are different than compliance. Those are two different issues.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct.

Deven McGraw - Center for Democracy & Technology – Director
No, that's right.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
When we originally wrote it in the second round, we did clarify that to not just allege, but you basically were convicted or found out of compliance, and that action would, in our proposal, have stopped your payments…. Okay. Moving off of the categories, it looks like CMS took us up on the adoption year strategy, which meant that regardless of which payment year you came in at, in your first, except for 2015, your first set of criteria you'd be held up to is stage one. Then they have a nice table one that shows how that works.

One of the implications, and I remember Tony asking me this question actually, is that, well, what happens if you do come in at 2015? What would you be measured against in 2015, and sort of the implication of our statement was that you'd still have to be held accountable to the criteria in effect at that time, and that's what's represented in this table. Now clearly that's challenging for folks coming in late, but is that a topic that we would want to discuss?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
What it does from the customer's perspective, again, like if we know it's going to take five years to implement these advanced systems, so we just don't know how to do it. And the second thing is, it puts pressure right now to know what's in stage two and stage three for us to get there. So it really impacts two things.

Neil Calman - Institute for Family Health - President & Cofounder
This is Neil. I think that I don't know if there's a solution to this, but I think that this is a real serious problem because it basically creates, first of all, it creates enormous pressures in the next year that then presumably would drop off somewhat. But in the first year that we're trying to do all of this stuff that the rec centers are getting up, that some of the facilitative mechanisms are being put in place to help people implement. That the same time that's happening, there's going to be an enormous flood of activity. I mean, the rec centers have to staff up. They have to do all of these things, so I would like to see this back on our agenda for discussion.

I think, if we really are interested in adoption, it's got to be something that has a glide path, the same glide path whether you start it this year, next year, or the following year. You can't be, you know, you can't say you've got learn how to fly in one year. If it takes five years to learn how to fly, you've got to learn how to fly in five years.

Christine Bechtel - National Partnership for Women & Families – VP
Yes, but I think it's definitely worth discussion. This is Christine. Maybe I don't; maybe there's something I'm completely missing, but I thought this was better than the approach that we worried about.

Neil Calman - Institute for Family Health - President & Cofounder
It is.

Christine Bechtel - National Partnership for Women & Families – VP
Given that you adopt in the first three years … you adopt in 2011 versus 2012. I'm just talking about eligible providers because the hospital math requires a trigonometry degree. And there's only a $5,000 difference … payment year. By the way, we have somebody breathing into the phone … really hard to hear folks. Yes, it drops off in 2014 more significantly, but I think it's hard to balance the need to really do something that folks have been wanting providers to do for a long time and deliver benefits to patients of a multibillion-dollar investment. I thought it was a pretty reasonable approach, but I'm open to, you know, if I missed something here.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We've successfully put it on the list to discuss.

Christine Bechtel - National Partnership for Women & Families – VP
Sorry.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, I mean, these are excellent points. Any other topics, not that you can't write them in when you think of it later? But from an organization point of view, you can tell this is going to be several hours of discussion. Our timeline is we need to be prepared to present. We're going to present sort of a top level view of all this so that the committee has a heads up, and the committee members will have some time to comment, as we have, during the meeting next week. Then we'll have to take that next month, and really let's say three weeks because we need to put it in a form that it can be presented and digested by the committee by the February meeting.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, I wonder if it would be. I'm worried about the payment year discussion in the policy committee, like, sucking all of the oxygen out of the room. It's something that people have a lot of energy around, and so I think it would helpful to start thinking about a way that we could have a dialog on this in particular, and maybe it's as simple as two different people sort of lay out pros and cons of this approach, and then there's discussion, so that we don't have to—

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good idea, very good idea. No, thank you. No, that's helpful. Some of these major topics will set that up. Thank you, Christine. In fact, we may – were you suggesting that for the main committee or for the workgroup calls?

Christine Bechtel - National Partnership for Women & Families – VP
I was suggesting for the full committee because I think there's a lot of energy in the full committee. I'm thinking about comments that folks like Gayle and others have made in the past.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. I'm wondering if that may be even a strategy for our workgroup call.

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

For the major topics, like you and Neil just volunteered yourselves….

Neil Calman - Institute for Family Health - President & Cofounder
Let's duke it out.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You have to duke it out, but it really helps. Then a lot of things have been said that we don't have to repeat, but also … thoughtful…. Very good. So you can see that this is going to be several hours. I'm guessing we've got sort of two, three-hour calls that we need to schedule in the three weeks after next week.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, Paul. You've got a couple already on the books. You've got January 28th and February 12th, so you need a few more, I think.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
January 28th, it's only two hours.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What's the other one?

Judy Sparrow – Office of the National Coordinator – Executive Director
February 12th.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's way too close.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, I know.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We'll have to extend the one we have and then find another one for three hours, so that we can try to – this clearly was the meat of the committee work in the first month. Once again, in this next few weeks, it will have to be the meat of the committee work because, I mean, it's a good thing. This is an extraordinarily important program. It's the crux of the HIT incentive program, and we need to do the best job we can. I think this group has clearly been committed throughout this to do that. We've had back and forth, and now the next round, I think, is in our court, ours and the public's court to try to give meaningful comments back so that CMS can make the next round. Any other comments before we open it up to the public?

Neil Calman - Institute for Family Health - President & Cofounder
Just a question about whether or not we should try to plan a committee meeting in person, though I hate to suggest that. But I'm wondering, is that impossible?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You know what? It's a great idea. That is a great idea.

Neil Calman - Institute for Family Health - President & Cofounder
I just think it's so hard to do some of this stuff over the phone. And if we're really going to get down to it, I'd rather make a trip and really slog through this than have to do this through three conference calls.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I totally agree and, first of all, I'd like to comment that this group has been extraordinarily productive for conference calls.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's really an asset. Judy, do you have any initial thoughts about why that might not be possible?

Judy Sparrow – Office of the National Coordinator – Executive Director
May I even suggest the day after the policy committee meeting?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
When is that date, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Pardon me? January 14th. Those of you that travel will already be here.

Neil Calman - Institute for Family Health - President & Cofounder
What about the day before and after?

Judy Sparrow – Office of the National Coordinator – Executive Director
The day before, we've got two workgroup meetings already scheduled, and that day before a committee meeting is horrible, to be honest.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's do this. Judy, can you organize a poll for us, both for that suggestion you've just made, as well as other dates that the committee could make in person for an all-day meeting?

Judy Sparrow – Office of the National Coordinator – Executive Director
I will do that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And let's try to get those on the books.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Can we open it up to the public? Any other comments from the workgroup members? Just an excellent call, very productive, and great suggestions.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right. Chris, remind me. I think we open the line up, but let me just say to the public, you're limited to three minutes for your comments, please.

Chris Weaver – Altarum
Thanks, Judy. Yes. For anyone who is following along online, if you're already dialed in, you just press star, one, if you want to make a comment. If you're listening online, and you wish to make a comment, you need to dial in. That number is 877-705-2976, and then press star, one, once you get dialed in. We have nobody at this very moment. We want to wait a couple minutes for anyone who wants to comment to get dialed in.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, while we're waiting, it's Christine. Do you think I could ask Tony a mechanical question? Tony, if you're there, my question is, can you just walk us through the mechanics of how the second payment year would occur? Let's say a meaningful user has been a meaningful user for a 90-day continuous period in their first payment year, and let's call it 2011. They did like October through December. For the second payment year, when do they have to start meeting the criteria, and when do they get a payment?

Tony Trenkle – CMS – Director of OESS
I can't walk you through it at this point because this is a proposed rule.

Christine Bechtel - National Partnership for Women & Families – VP
Right, but can you walk me through the proposed process that's in the rule?

Tony Trenkle – CMS – Director of OESS
In terms of the second payment year?

Christine Bechtel - National Partnership for Women & Families – VP
Yes. In other words, I'm trying to get a sense of, for the requirement in stage two, somebody who has met stage one in, let's say, 2011.

Tony Trenkle – CMS – Director of OESS
Stage two doesn't begin until 2013.

Christine Bechtel - National Partnership for Women & Families – VP
Okay, so they just have to keep doing the same thing in stage one that they were doing for the 90-day period in 2011 for 2012.

Tony Trenkle – CMS – Director of OESS
Correct. Right.

Christine Bechtel - National Partnership for Women & Families – VP
Okay. That makes – that's what I needed to know, so that gives them 2012 to ramp up for stage two.

Tony Trenkle – CMS – Director of OESS
Exactly. Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Tony, a question in terms of that 90-day period, does that apply for the first year for any stage one, so like if I started in 2011 or 2012 or 2013, it's just 90 days for year one?

Tony Trenkle – CMS – Director of OESS
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's what we read.

Tony Trenkle – CMS – Director of OESS
Yes, that's correct. Yes, if that's not clear….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
No, it's there. It's just like we weren't….

Christine Bechtel - National Partnership for Women & Families – VP
It was too good to be true, Charlene?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right. The customers were jumping up and down.

Tony Trenkle – CMS – Director of OESS
Yes. I mean, that's why we proposed a certain way because of the fact that … you have the stage one requirements. You also have the shorter reporting period, and then you ramp up, as you move to stage two.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
In your second payment period, so in the first, you could qualify, let's say, quarter one with the 90 days, get paid some time in quarter two possibly in 2011. In 2012, to collect your second payment period, your reporting period is the entire payment year in that case?

Tony Trenkle – CMS – Director of OESS
Yes.

Christine Bechtel - National Partnership for Women & Families – VP
But you're still meeting the same criteria you just met for 90 days.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Tony Trenkle – CMS – Director of OESS
Right, but you'd have to demonstrate it over a full year.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So the full year is, let's say if you qualified in quarter one 2011, you got paid, then when can you get paid for second payment year in 2012, and based on what reporting period?

Tony Trenkle – CMS – Director of OESS
The entire year.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The entire 2012?

Tony Trenkle – CMS – Director of OESS
Right, that's what we've proposed.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And then you would essentially get paid in the first quarter of 2013.

Tony Trenkle – CMS – Director of OESS
Correct.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And the other assumption that we made is like, if I miss a year, say I'm going 2011, 2012, but I don't get to stage two, then I just miss that year, and I have to get to stage three, so we're just assuming once you start, you start.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
…say, if you moved your hospital, and somehow you didn't move your PHR or something?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right, you didn't….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You start with the calendar that you started with.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Once you start, you start, and you've got move up those stages, or you just don't get paid, if I don't make it to stage two that year, like year three or whatever.

Tony Trenkle – CMS – Director of OESS
I'd have to go back and reread what we've put in the proposal. I'm not going to say yes or no….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Okay. Because those questions will come in….

Tony Trenkle – CMS – Director of OESS
Yes, that's the kind of questions that if we haven't been clear about, we may have to add some clarity … reg.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, I'd like to repropose my original idea, which somehow got turned into a face-off, and that … with Tony or somebody just explaining what's in the proposed rule because I think having it be this 90-day thing, it changes a lot, I think, the heaviness of the requirements, stage one, stage two, calendar one, calendar year, payment year. I think we have to understand that at the policy committee level, but also at the workgroup level before we can understand whether the requirements are reasonable vis-à-vis the payment years.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Would you be amendable to that, Tony?

Tony Trenkle – CMS – Director of OESS
Yes, I think so.

Christine Bechtel - National Partnership for Women & Families – VP
Thank you, Tony.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think what happens is that will diffuse some of the confusion, but then I think it's still nice to have the – it's not a face-off, but it's an organized way of getting the points out that we can efficiently make a decision. And we can identify by e-mail those areas, the hospital based physician, the adoption year. There's only a handful where we really need that level of preparation. Very good.

Judy Sparrow – Office of the National Coordinator – Executive Director
Do we have anybody from the public on the line, Chris?

Chris Weaver – Altarum
Judy, we have no public comments at this time. One reminder to folks, if you make comments via the Web in written format via the public comment section of the screen, those comments are not read aloud, but will be delivered to members and will be made part of the public record.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Once again, I want to thank all of the folks, the participants for this very productive call and look forward to our scheduling, our intent to come together so that we can provide useful feedback for ONC and CMS, and look forward to seeing you next week.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you all.

Tony Trenkle – CMS – Director of OESS
Yes. Thank you, Paul. This has been very helpful.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Very helpful.